DURABLE MEDICAL EQUIPMENT

(FY2007 Appropriation Bill - Public Act 330 of 2006)

April 1, 2007

Section 1735: (1) The department shall establish a committee that will attempt to identify possible Medicaid program savings associated with the creation of a preferred provider program or an alternative program for durable medical equipment, prosthetics, and orthotics. (2)To assure quality and access, the preferred provider program shall involve providers who can offer a broad statewide network of services and who are accredited by the joint commission on accreditation of health care organizations or the accreditation commission for health care, inc. and the American board for certification in orthotics and prosthetics. (3) This committee shall include, at minimum, representatives from each of the contracted Medicaid HMOs, the medical services administration, the Michigan state medical society, the Michigan osteopathic society, the Michigan home health association, the Michigan health and hospital association, and 2 accredited providers. (4) By April 1, 2007, the committee shall report to the senate and house of representatives subcommittees on community health, the state budget director, and the department on possible durable medical equipment contracting opportunities and anticipated Medicaid program savings.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor
Janet Olszewski, Director

Report of the Committee on Durable Medical Equipment, Prosthetics and Orthotics Mandated by Boilerplate Section 1735 of P.A. 330 of 2006

Medicaid purchasing arrangements for durable medical equipment, supplies, orthotics and prosthetics

I. Committee Representatives

A committee of representatives as described above convened two meetings to review and discuss the following Medicaid durable medical equipment, medical supplies, prosthetics and orthotics (DMEPOS) purchasing arrangement options. A list of participants is attached.

II. Option Constraints/Considerations

All options must include consideration of the constraints outlined in federal regulations that govern the Medicaid program. These requirements allow a competitive bidding process for "medical devices" without requiring a federal waiver. However, Medicaid cannot mandate that Medicare/Medicaid dually eligible beneficiaries obtain products through a competitively bid purchasing contract unless the products are not covered by Medicare.

III. Proposed Options

A. Preferred Provider Contracting, Statewide Sole Source

Virtually all providers strongly opposed this option for a variety of reasons.

1. Decreased access and convenience for beneficiaries, especially in rural areas and the Upper Peninsula.
2. Loss of local face-to-face provider support, teaching, product service, repair and follow up for beneficiaries. There is a very significant service component with many of these devices/suppliers that adds complexity to contract purchasing methods.
3. There would be resulting delays in hospital discharges.
4. In anticipation of increased mail order distribution of DMEPOS, it was noted that there are limited types of products that can/should be shipped to beneficiaries.
5. There would be a negative impact on many providers who are small local businesses. These providers would be put out of business.
6. It is possible that an out of state company could be selected which would further harm Michigan's business economy.
7. There is a concern that lower quality products and an extremely limited range of products will be provided under a contract. Losing a wider range of products to meet the specific needs of beneficiaries will have a negative clinical impact. For example, there is a wide variety of ostomy products that are needed to meet individual needs of ostomy patients. The outcome of limiting access to a smaller array of products that do not work well for the patient, may be an increased need for costly medical care. The Michigan Home Health Association (MHHA) requests that ostomy supplies, custom orthotics and prosthetics be exempt from any contract.
8. Contract development and the competitive bidding process will take up to a year therefore no immediate savings will be achieved.

Benefits of this option:

One provider asserted that provider accreditation requirements and quality standards can be built into a competitively bid contract. The State should put out a Request for Information (RFI) where either one provider or a group of qualified providers could submit a bid proposal for consideration. The State does not have to complete a contracting arrangement if sufficient cost savings will not be realized.

Implications Of Other Activities:

1. **Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services, DMEPOS Competitive Bidding Program**
   CMS is preparing to phase in implementation of the Medicare DMEPOS Competitive Bidding Program for certain covered items in select areas later in 2007. Detroit is on the list as one of the 25 possible areas that could be selected as competitive bidding sites for this program. The bidding will be used to determine prices for certain DMEPOS covered by Medicare Part B, to reduce the amount Medicare pays for DMEPOS and bring the reimbursement amounts more in line with a competitive market. Medicaid should wait for the Medicare pricing results before pursuing any reimbursement change.
2. **Medicaid Health Plan (MHP) DMEPOS Contract**
   Individual Medicaid MHPs have DMEPOS contracts for services provided to their members. No information is available to compare MHP contract rates with Medicaid established fee for service rates. At this time the Michigan Association of Health Plans is exploring the possibility of pursuing a DMEPOS contract for the benefit of all member health plans. The Association agreed to share information from the development of this proposal with MDCH so that the department can gain from their experience and evaluate the potential benefits of a DMPEOS contract. MDCH should not pursue any special purchasing arrangements until the results of this project are known.

B. Set Reimbursement at New Medicare Median Rates Or Set Rates Based On Median Price Submitted By Providers

The payment for an item provided under the Medicare Competitive Bidding Program will be 80% of the established single payment amount related to the median of the medical supplier bids accepted for that product category. Medicaid should follow the Medicare median rates. However, Medicare does not cover all the products that Medicaid covers and the bidding process will not be completed for some time. MDCH should consider soliciting provider rates and setting the Medicaid rate at the median price received. The state could achieve savings and still allow all willing providers to continue to participate and serve Medicaid clients. This option would require a considerable amount of time for an evaluation and there is no guarantee that there would be optimal savings for the time invested.

C. Medicaid Across The Board Rate Reduction

Medicaid providers would rather consider an across the board rate reduction to save money than a contracting arrangement that would harm loyal Medicaid providers while creating a huge windfall for one provider or group. However, there may be some smaller and rural providers who could not continue to serve Medicaid beneficiaries if rates are cut too low. Consideration should be given to allowing a rural add-on to preserve access.

A separate option would be for Medicaid and the providers to jointly review product groupings and devise selected rate reductions.

Michigan Orthotics and Prosthetics Association is opposed to any rate reduction and stated that they should be exempt from any contracting arrangement because CMS has exempted orthotics and prosthetics from the Medicare competitive bidding program.

D. Product Formulary and Rebate Program

The state should consider establishing a formulary of products by negotiating directly with manufacturers for guaranteed prices and possible product rebates based on volume. The state can achieve savings without penalizing providers by cutting Medicaid rates. All willing providers can distribute the products.

A formulary would result in a limited range of products available and beneficiaries would not be afforded an array of product choices. The administrative costs of establishing and administering a formulary and negotiating contracts with manufacturers would likely offset the limited financial net gains.

IV. Cost Savings

The Committee reviewed FY 2005 data from the Medicaid Fee For Service population. There were 98,424 beneficiaries who received DMEPOS services. Ofthese, 44,178 were Medicare/Medicaid dual eligibles. There were 21,625 Medicaid/Children's Special Health Care Service beneficiaries and 32,621 Medicaid only beneficiaries who were not in a MHP at that time.

Total DMEPOS Medicaid spending was approximately $53.5m. However, subtracting spending for duals (who cannot be mandated into contractual arrangements) and subtracting services already subject to a statewide contract, reduces spending to roughly $30.5m.

Using an updated 2008 federal funding percentage rate of 58.1%, the federal share of that amount would be $17,749,948 leaving the net cost to the State of $12,800,692. It has been suggested that contracting services for the fee for service group of Medicaid/CSHCS non-Medicare eligibles could save as much as 10% or $1,280,069. This amount of savings can be achieved in other ways such as rate reductions that would not involve the additional administrative costs that competitive contracting or formularies require.

V. Overall Medicaid DMEPOS Program Savings Recent History

MDCH has implemented a variety of successful DMEPOS cost saving measures since 2005. These coverage and reimbursement changes included all fee for service eligibility groups with the estimated annual program wide savings noted below.

May 1, 2005	4% fee reduction for non-contract DMEPOS fee screens Manually priced items limited to acquisition cost +19% (was 20%) Labor payment decreased 4% $48 cap for Orthotics & Prosthetics repairs (was $50)	Estimated $1.26 million Annual General Fund savings
July 1, 2005	Reduced oxygen concentrator rental rate from $192.39 to $160.33 month	$3,500,000
January 1, 2006	Pharmacy dispensing fee savings from moving certain diabetic supplies and enteral formulas from pharmacy coverage to medical supplier	$215,660
January 1, 2006	Enteral formula HCPCS codes without established fee rates reduced from AWP +19% to AWP - 13.5%	$345,649
July 1, 2006	Oxygen Concentrator monthly rate reduction for Nursing Facilities from $160.33 to $112.23	$711,928
November 1, 2006	Enteral Formula HCPCS codes without established fee rates reduced to AWP -20% Blood Glucose test strips rate reduced to $29.55	$46,662 $979,676 (FFS rate and Coin savings)

VI. Conclusion

The committee preferred any option that preserves the established provider network and access for beneficiaries. The State should monitor the DMEPOS purchasing proposals of Medicare and Michigan Medicaid MHPs to determine the value of any further reimbursement revisions and assure payment coordination with those entities.

DMEPOS WORKGROUP ATTENDEES

NAME	DEPT./ASSOCIATION
Appel, Laura	MHA
Baker, George	MDCH
Bartz, Michael	MHHA
Beattie, Wendy	A-S-C Orthotics & Prosthetics/Becker Ortho.
Bennett, Loren	J & B Medical
Boggs Joan	MDCH
Brewster, Darwin	Sparrow Regional Medical Supply
Broessel, Kristi	MDCH
Bupp, Cheryl	MDCH
Cole, Jim	Cole Rehab Technologies
Damstra, Mike	Careline Medical Equipment & Supply Co.
Farhat, Leo Jr.	MSMS
Fasse, Kenneth	Northwood, Inc.
Greaux, Evelyn	MDCH
Hambright, Julie	M-Caid
Hatt, Tim	Wright & Filippis
Hinds, Germaine	MDCH
Hornberger, Toni	MDCH
Jones, Cathy	MDCH
Kemp, Ed	MDCH
Liberman-Lampear, Anita	Michigan Orthotics & Prosthetics Association
Mattoo, Raj	Moline Healthcare of Michigan
McCarty, Mary Ann	Community Choice of Michigan
Mitchell, Eugene	M-CAID
Moran, Susan	MDCH
Reinhart, Paul	MDCH
Russell, Mary Jane	MDCH
Schick, Jack	Karoub Assoc./MOPA
Serra, Steve	MHHA/Henry Ford Health
Shearer, Christine	Michigan Assoc. of Health Plans
Shurlow, Jim	MHHA/University of Michigan
Slater, Steve	MHHA/Airway
Smalley, John	Muchmore Harrington Smalley & Assoc.
Stokosa, Jan	MOPA
Teter, Michael	Teeter Orthotics & Prosthetics
Trower, Ted	A-S-C Orthotics & Prosthetics/Jackson
Williams, Steve	MOPA
Zuckerberg, Harvey	Michigan Home Health Assoc.